Chapter 2
Global Response to Social and Health Inequities

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International technical and cooperation agencies, such as the World Health Organization (WHO)/Pan American Health Organization (PAHO), the International Union for Health Promotion and Education, and the Economic Commission for Latin America and the Caribbean (ECLAC), among others, have provided a valuable impulse to strive for social equity, which, according to López Arellano et al. (2008:326), "is a fundamental objective of global development programs, which use a framework based on indicators of social determinants to measure the accomplished goals."

Oxfam's report emphasizes the need to measure the impact of public policies aimed at reducing inequality, expand the state's redistributive capacity through the treasury, end legislation and regulation that protect the privileges of the few, and advance the empowerment and democratic participation of vulnerable and excluded groups; these are essential elements in reducing the intergenerational transmission of inequality in the region (Lustig 2016). Latin America has long fought for human rights and equity; however, its adoption on the regional agenda has yielded results that fall far short of expectations, and sometimes the decisions taken have intensified inequities.

Health must be understood as a result of interconnected sociopolitical phenomena that operate under multidimensional and complex power structures. In the following paragraphs, more inputs will be presented to perform analyses that are closer to our particular reality. Development as a universal right places the human being as the central subject. The development notion is composed of several levels (local, departmental, regional, national), spatial areas (territory), and approaches (decentralized, sustainable, participatory), which should not be separated from the notion

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of individual development, empowerment, and active social participation. The dimensions (population, environmental, economic, and social) essential for development require a broad perspective and a systematic approach that involves interactions among constituent elements, the whole and the parts.

The evolution and scope of policies and programs aimed at reducing health inequities have been mediated by the emergence of new theoretical approaches and strategies for creating and maintaining a population's health, as well as new approaches and mechanisms adapted to each country's particular conditions. In this sense, the implementation of primary healthcare (PHC), health promotion (HP), and health in all policies (HiAP), among other strategies, has not been autonomous but, on the contrary, has been influenced by global socioeconomic contexts, embodied in neoliberal policies on which the globalization phenomenon rests.

> Despite some empirical studies that show significant correlation between the efforts of the globalization process and the specific impact on health, the existing weaknesses in the empirical evidence are more linked to the problem of globalization and health. Mention of the conceptual framework could make a major contribution to further empirical research that should serve as a well structured model for further consideration. This clearly shows the need of interdisciplinary approach towards globalization and health, which will draw knowledge from relevant fields, such as medicine, epidemiology, sociology, political science, health, education, the science of ecology and economy. (Kovačić 2014:694)

Global Response to Social and Health Inequities

Improving Income and Health Outcomes

According to Chossudovsky (2002), "a dollar a day" (poverty threshold) is part of the ambiguous standards of "scientific" poverty measurement, inconsistent with the real situation of various countries. In this regard, the author mentions some factors (unreliable systems in the quality of the data obtained) and argues for the existence of adjustments of parameters or estimates of poverty deliberately convenient for some institutions and interest groups, which are not in line with the reality of a huge part of the world's population:

> The World Bank and United Nations poverty assessments are, to a large extent, desk exercises conducted in Washington and New York with insufficient information on the local reality. For example, the UNDP Poverty Report points to a one-third or one-half drop in child mortality in sub-Saharan Africa, where poverty has actually increased and public health programs have collapsed. What the report does not mention is that as a result of the closure of health clinics and the massive layoffs of health professionals (often replaced by semi-illiterate volunteers) responsible for compiling mortality data, the computation of mortality is what has been reduced. These are the realities deliberately hidden by the poverty studies from the World Bank and UNDP. Their indicators blatantly misrepresent the social reality of the different countries, as well as the seriousness of poverty in the world. The "free market" system is seen as the most effective means of alleviating poverty, while the impacts of macroeconomic reforms are denied. Both institutions point to the benefits of the technological revolution and the contribution of foreign investment and trade liberalization, but they do not indicate how these global trends increase the poverty levels. (2002:43)

Studies from ECLAC show that employment opportunities arising from market reforms and trade liberalization are concentrated in low-productivity sectors, and therefore, these reforms tend to further widen the gap between winners (i.e., skilled workers in successful enterprises) and losers (i.e., unskilled workers or employees in low-productivity enterprises in the informal sector). According to this interpretation, the opening of the region's economies to globalization produced higher incomes for those with higher education while harming those with less formal education (Korzeniewicz and Smith 2000:394). These facts indicate the urgent need to eradicate poverty in our countries. Most Latin American countries in the 1980s and 1990s developed policies and programs to combat poverty. The results achieved brought not only the gradual incorporation of complementary aspects such as the identification of risk factors, balance of power relations, methodological issues about measurements, and analysis, among others, but the introduction of new conceptual and methodological approaches.

The poverty–vulnerability relation has generated two radical changes in the policies of poverty reduction: (a) emphasis on enhancing the available resources of poor sectors, rather than the observation of what is not possessed; and (b) the vulnerability assumed as the risk of a fall in well-being levels, an immediate step to impoverishment, must be faced by these sectors through a mobilization of resources and activation of strategies to prevent and reverse impoverishment (Busso 2005:16).

There is an imperative need to eradicate or reduce poverty if substantive changes are to be made to the health conditions of populations. Perhaps one of the most important aspects is to identify how to narrow the gap between rhetoric and the real and effective commitments of states.

Extreme Poverty Eradication in Latin American and Caribbean Countries

The World Bank defines extreme poverty based on the available economic range of people who live on less than US$1.25 per day. The World Bank estimates that, by this definition, 1.4 billion people lived in poverty in 2008. Poverty is also treated as a state of scarcity of economic, social, cultural, institutional, and political resources that affects populations with the greatest accumulated disadvantages, who therefore live with minimal basic capacities to reverse unfavorable conditions. This reality is mainly associated with labor market conditions, instability, informality, low wages, and job insecurity.

The average unemployment rate in Latin America has decreased according to ECLAC (2015), which, together with the International Labor Organization (ILO), affirmed that the unemployment rate in Latin America and the Caribbean in 2012, at 6.4%, had been the lowest in recent decades, after declining from 6.7% in 2011, a positive figure considering the difficult labor situation in other regions of the world. According to ECLAC (2015), the average of the official unemployment rates in the countries of the region fell again, from 6.2% in 2013 to 5.9% in 2014, bringing it to a new historical low (López Segrera 2016:27).

Poverty analysis requires a systemic view (underlying macroeconomic and structural causes of monetary and nonmonetary poverty), accounting for its multifactor

character: economic, social, political, cultural, historical, and territorial. An increase in poverty is dynamic; it does not occur through a single pathway or in a unidimensional way; its impact affects different vital areas of individual lives and social groups. Therefore, a multidimensional poverty index is used to quantify it.

In this perspective, ECLAC has insisted that social policy must have the capacity to influence the structural determinants through which poverty and inequality are transmitted from generation to generation: misdistribution of educational and occupational opportunities, the pronounced inequality in the distribution of wealth, high demographic dependency, and the ethnic and gender dimensions of poverty. Education is a mandatory route for equitable growth, democratic development, citizenship consolidation, and personal development. However, this set of virtuous relationships should not hide the fact that in a segmented society, education is also an instrument of social segmentation and cannot be approached apart from the influence of the other structural factors mentioned, particularly the generation of quality jobs that effectively make possible the use of human capital (ECLAC 2003:27).

In this sense, the technical teams of ECLAC and the United Nations produced a document (2013) to facilitate and support discussions among countries in the follow-up to the agenda for post-2015 development and Rio + 20. One of the seven central messages referred to the need to raise the minimum well-being threshold for populations, for which "change must be based on universalist state policies (social protection, health, education and employment)…" (ECLAC 2013:9). There is growing evidence that supports the existence of a link between income inequality and health results. These results should alert authorities, officials, and the public to the need to fight income inequality and rethink the role of international financial institutions that dictate state policies (Cruz Ferré 2016:501).

The economic poverty of individuals, together with the exclusion of some fundamental social relations, increases social vulnerability. Exclusion must be understood as an expression of the process of social disaffiliation (Castells 1995 in De Roux 2008), a factor that is part of the set of disadvantages accumulated along the trajectory of thousands of vulnerable individuals for an indefinite period with a historical incapacity for individual and collective response. Income distribution should be a matter of concern for ethical considerations of social justice. If the distribution of income exclusively reflected personal preferences for work, effort, and saving, it would not have to constitute an ethical problem from the point of view of distributive justice. If the differences between individuals were limited to the scope of their personal responsibilities and preferences, it would be morally reprehensible to interfere in their behavior to improve income distribution. Inequality and poverty become an ethical issue that demands external intervention when it is recognized that the conditions generating them are not a result of individuals' choices but the legacy of the past or circumstances beyond their control.

> Once it is recognized that effort and attitudes towards education, work, risk and savings are not independent of the initial conditions of each individual, it opens space for other concerns. It is not simply about ensuring "equality of opportunities." If equality of opportunity is understood as equality of access (free basic education), this will not be enough to ensure equality in the use of capacities (school attendance), and even less equality in the results

> (academic achievement). According to the objectives of social justice pursued by the society in each field, policy actions should be directed to altering the distribution of the capacities of use (school subsidies, for example) or the distribution of results (leveling programs and other supports). (IPES 1999:23)

By the updated poverty line of $1.90 a day, the estimate for 2012 indicates that 900 million people, or 12.7% of the worlds' population, lived under conditions of extreme poverty in that year (Global Monitoring Report 2015/2016 2015:3). In the case of Latin America and the Caribbean, there was a decrease in the proportion of the population that lived on less than US$1.90 per day according to purchasing power parity values (2011), with results of 17.8 (1990), 13.9 (1999), and 5.9 (2011). Despite these figures indicating progress in poverty reduction, enormous, permanent, and timely efforts are required, together with the empowerment and implementation of strategies to "end poverty in a sustainable manner and promote shared prosperity, taking into account the demographics as the countries promote broad-based growth, invest in human development, and insure against emerging risks" (Global Monitoring Report 2015/2016 2015:22).

López Segrera (2016) stated that "poverty reduction and middle-class growth in the last ten years is related to the dynamics of growth and job creation, as well as to the social policies of progressive post-neo-liberal governments." Employment and health are considered primary aspects of the category of human well-being. Thus, increasing job offers (improving those of temporary nature and remunerative precariousness) is one of the main concerns of the countries of the Latin American region.

In 2002, 225 million people were living in poverty. From 2008 to 2014, this number decreased by 58 million people, but the millions of people living in indigence or left homeless grew by five million in the period 2012–2014. Poverty was reduced, but indigence gradually increased. Perhaps this information on the reduction of poverty is due to two specific developments. The first has to do with the intervention and sustainability of social assistance programs and the second with the adjustment of parameters or new estimates of poverty (threshold) in recent years.

Millennium Development Goals

The millennium development goals (MDGs) and sustainable development objectives (SDOs) were established to reduce or eradicate key aspects in the living conditions of the poorest people. In 2015, the United Nations coordinated efforts toward sustainable development goals to strengthen the effects of the millennium goals. The central purpose was to minimize poverty, promote prosperity and well-being for all, protect the environment, and address climate change. In addition to the human aspects, the sustainable development objectives considered a wide range of related aspects such as security, disaster risk reduction, well-paid work, conflict prevention, and animal diseases.

> The MDGs have been successful at reducing income poverty but not so much at improving non-income deprivation, such as access to quality education or basic health services. Few countries have combined growth with a reduction in the level of environmental externalities and carbon emissions and the increase in environmental degradation, overfishing, deforestation, extreme weather events and air pollution in the cities, all of which threatens recent progress. Looking to the future, three challenges stand out: the continuing depth of poverty, inequality in shared prosperity, and persistent disparities in non-income aspects of development. (United Nations 2013:1)

The year 2015 marked the transition from the MDGs to SDOs, whose goals are aimed to reaching the highest levels of reduction of social inequities through various processes and strategies, established within a framework of integral sustainable development as the central idea. The SDOs address not only poverty reduction but also other phenomena that deeply affect millions of lives, projecting an ideal "end of poverty" scenario. However, the accomplishment of an objective of this complexity exceeds the possibilities of individuals and collectivities—and sometimes of entire countries; it demands a long-term process that focuses on political-economic policies capable of generating structural changes that are not dependent on changes in government.

> The road map–as the SDO underlines–goes through a more synergistic approach among the various aspects of development. Three ingredients will form the political agenda: broad-based sustainable growth, investment in human development, and measures to protect the poorest and most vulnerable against emerging risks. These strategies must be sensitive to demographic issues. Countries at the epicenter of global poverty need to accelerate their demographic transition, invest in their youth and growing populations, and lay the foundations of sustained growth to capture demographic dividends. (Global Monitoring Report 2015/2016 2015:2)

Sustainable Development Objectives

The MDGs constitute a key opportunity to reduce the negative effects of socioeconomic and political phenomena such as poverty, vulnerability, social exclusion, and social and health inequities, with the strong political support of various governments of the world. The world met the MDG of halving the global poverty rate by 2010, 5 years before the original target date. Recent data suggest that extreme poverty has continued its downward trend in recent decades. However, poverty remains unacceptably high, with an estimated 900 million people living below US$1.90 per day in 2012—the new international poverty line; in 2015, the estimated figure according to the new threshold is 700 million (Global Monitoring Report 2015/2016:1).

A review of key indicators reveals that Latin America and the Caribbean have made significant progress toward the achievement of the MDGs, particularly in reducing extreme poverty, hunger and malnutrition, child mortality, and access to water. These developments, however, are not enough to close the gaps between rich and poor and overcome the lags that have characterized the region (United Nations 2013:12).

Main Agents of Change
Small producers,
Family farmers,
Rural women,
Fishermen,
Indigenous communities,
Youth and other vulnerable or marginalized groups.

FAO and SDG (2015:1)

The Food and Agriculture Organization of the United Nations (FAO) documents and the 17 Sustainable Development Goals (2015) emphasize the need to achieve a reduction or elimination of hunger and malnutrition to reach the SDOs. They also point out the need to focus on a particular part of a given territory and on specific actors to put into operation processes of change.

In this way, the rural zone is the key area in which interventions must be carried out, based on the existence of a political will; as for actors, the following have been identified as the main agents of change: small producers, family farmers, rural women, fishermen, indigenous communities, youth, and other vulnerable or marginalized groups (2015:1). The FAO document identified some measures that should be considered for the eradication of extreme poverty and hunger by the year 2030: combining pro-poor investment in sustainable agriculture and rural development; transformation of existing food systems, which employ a large amount of inputs, to make them more sustainable—including by reducing food waste—through better management and better techniques in agriculture, livestock, fisheries, and forestry (2013:1).

> FAO has identified five strategic objectives to refine its focus on the fight against hunger and to create food systems that are more sustainable. This places the Organization in a strong position to support countries that are taking the lead in implementing the Sustainable Development Goals. Through its international experience, FAO is also well positioned to provide support to broad regional and international partnerships, including South-South cooperation, needed to achieve zero hunger by 2030. (2015:7)

The capacity exists to produce enough food to eradicate the chronic hunger of hundreds of millions. However, that capacity cannot be guaranteed because of a lack of access to stable and decent jobs that would make it possible to earn income enabling people to purchase basic food items.

Global Health

Global health is defined by Frenk and Gómez-Dantes (2007:162) as "a field of knowledge [that] involves the interdisciplinary study of the health-disease process at the global level and the social responses generated to deal with this process." PAHO

(2013), quoted by Franco (2016:128), proposes the following definition: "transdisciplinary approach that addresses health from the perspective of the universal right to health and social welfare." Global health is population health in a planetary context, defined as an area of study, research, and practice that emphasizes health improvements through the achievement of equity in health for all and protection against global threats that cross national borders. It shows three determinant tendencies that mark the distance from the central idea of international health, historically nested in the interrelations between countries of a region or at the intercontinental level:

(a) The increasing international transfer of risks and opportunities for health; (b) greater pluralism in the arena of international health, with an accelerated growth in the number of actors; (c) the increasingly critical role of health within the agenda of economic development, global security and democracy.

> The global health approach in Latin America should take as its starting point a characterization of the phenomenon of economic globalization and its impact on equity in access to health services and general well-being of the population. (Solimano and Valdivia 2014:360–362)

The global health concept has shifted its focus, moving from the problems of the developing world to health problems with a global impact. These approaches recontextualize key aspects such as health inequities, human health, the global environment, and climate change. Global health requires thinking about the immediacy of interactions in an interconnected world, threats to it, and its simultaneous and unavoidable opportunities. Daulaire (2003) argues about the importance of acting in the present with regard to global health promotion in order to predict optimal results in the medium and long term:

> To view global health promotion as a means to ensure optimal market access, the forces that drive globalization can be channeled to promote global health, regardless of their motivations for taking action. If solutions are devised to meet the social and economic needs of the current decade, it will be easier to meet (and exceed) those of successive decades. All sectors have the opportunity to join the global alliance of organizations bound by a self-sustaining commitment to promote global health. It is the task of this alliance to ensure that health is placed—by public and private demand—at the top of the global agenda. (2003)

Global health is also understood as a global category (Franco-Giraldo 2016); it differs from international health, which focuses on developing nations and foreign aid for these countries. Koplan et al. (1994) in Clavier and De Leeuw (2013) established a comparison between the concepts of global health, international health, and public health. Through geographic scope they identify direct and indirect issues that affect health; by transcending national borders, health-related issues could further

affect low- and middle-income countries (LMICs). Therefore, the joint development and implementation of solutions are required in a global instance of cooperation. This is a measurable objective and a category of health status connected to risk factors that are variously cross-border, transnational, or global in nature. These risk factors are loosely grouped under the heading globalization, and in such terms, globalization is viewed as a process capable of generating an equally loose category of global health, which incorporates a specific set of crises and problems that can be characterized as a global system of disease (Kay and Williams 2009).

> The concept of "global health" has become a mainstay of the scholarly discourse since the late 20th century. This has happened because governments and the aid industry abandoned the notion of "international health", which was considered by many to be limited....Global health appears to have greater appeal, greater urgency, and more forceful mobilization than its predecessors do. (Clavier and De Leeuw et al. 2013:104)

Thinking about global health involves thinking about the ways in which it can be regulated globally. According to Clavier and De Leeuw (2013), "If individuals, NGOs, and national governments, as well as international organizations, can drive the global governance of health, then traditional theories of international relations alone cannot predict how this governance will work. This means that analysts need new sets of theoretical tools to analyze global health governance." New sets of theoretical tools are therefore needed to analyze global health governance. In that sense, it is important to define what is understood as governance. According to Rasanathan (2011:13), the term *governance* "refers to the way governments (including their different constituent sectors) and other social organizations interact, in the way these agencies relate to citizens and how they make decisions in a complex and globalized world." Global health occupies a very high place in the international political agenda, but in Latin America it is still considered a field under construction, according to Solimano and Valdivia (2014) and Franco-Giraldo (2016).

Urban Health and Healthy Cities Movement

These two strategies have similarities in their theoretical basis but differ in their implementation, which is bound to the political, geographic, and economic contexts. Thus, different demands, challenges, and, therefore, mechanisms, as well as circumstances and conjunctures, influence the processes, methodological tools, and impacts. Therefore, we will take a quick look at the dynamics of these processes from the perspective of practical experience to meet the established criteria concerning public policies, legislative intersectoral work, inclusive participation to balance power relations, agreements supported in budgets to undertake operational plans, and local capacity.

The need to address social, economic, and environmental factors to improve health outcomes has been recognized in international and country meetings and agreements, country policies, and published articles; at the same time that by politician, researcher and health practitioner (WHO 2017). Despite this recognition, the

advances have not met expectations, mainly in LMICs. This is not the case for developed countries according to a WHO Europe publication, which clearly shows structural advances in small cities to address intersectoral actions to improve health:

> Effective intersectoral action is crucial to address today's biggest public health challenges. Health and well-being are affected by social, economic and environmental determinants. A successful policy response to address these determinants therefore necessitates an approach that is intersectoral. Increased involvement and coherent cooperation between actors in different sectors are necessary to achieve strategic goals. Intersectoral action is both a precondition for and an outcome of all dimensions of sustainable development.…Many sectors were involved in the country case stories, with the health sector taking the lead in most cases, coordinating action and engaging other players. The other main sectors involved in intersectoral action were agriculture, education, family affairs, interior, labour, justice, sports and tourism. Non-governmental organizations played active roles in intersectoral actions in addition to private entities such as the media. (WHO 2016: xi)

Big differences in the progress achieved between developed and developing countries, as well as within municipalities and countries of the same region, are well documented. According to the study "Healthy cities. Promoting health and equity—evidence for local policy and practice" by De Leeuw et al. (2014), progress among cities and networks differs in scale and quality. LMICs have experienced structural failures, but this does not mean that nothing has been done; on the contrary, there is regional movement to strengthen the capacity of cities and municipalities to intervene.

Within this movement, one critical aspect is the study of experiences in terms of satisfying principles, highlighting favorable and limiting factors.

A vision, project, and movement engages local governments in health development through a process of political commitment, institutional change, capacity building, partnership-based planning, and innovative projects (De Leeuw et al. 2014).

The healthy cities movement promotes comprehensive and systematic policy and planning for health and emphasizes the need to address inequality in health and urban poverty, the needs of vulnerable groups, participatory governance, and the social, economic, and environmental determinants of health (De Leeuw et al. 2014).

According to Caicedo-Velásquez et al. (2016:75), "Urban governance promotes well-being and health as it provides platforms that enable citizens to improve their social and economic conditions using their own capabilities."

> Governance will provide the normative, technical and administrative guidance for the different levels of public administration (MSPS, Department/District and municipalities), as well as health insurers and providers, to organize their management processes to achieve health results, based on the articulated action of the sectors involved. (MINSALUD 2016:32)

If individuals, NGOs, and national governments, as well as international organizations, can drive the global governance of health, then traditional theories of international relations alone cannot predict how this governance will work. This means that analysts need new sets of theoretical tools to analyze global health governance. (Clavier and De Leeuw 2013).

Theoretical Approaches and Strategies to Reduce Health Inequities

Different perspectives and theoretical approaches of interventions are aimed at reducing health inequities. This search has led to several ideological positions that reflect a certain conception of health and its relation to equity. In addition, a real willingness to transform power structures and public policies related to the asymmetric distribution of resources and opportunities in the population. The diverse and complex issues concerning the application of these theoretical approaches and strategies demand from governments and society as a whole commitments and responsibilities that go far beyond what has been done until now in terms of policies, legislation, regulation, health system transformation, and relations among territorial structures. Multidisciplinary and interdisciplinary research approaches are important for understanding this issue.

The main responses to health inequities from the health sector are represented by PHC, HP, and HiAP strategies. These strategies have revolutionized the paradigms of public health, mainly in two dimensions: first, through preventive basic care and universal coverage and, second, by addressing political and social dimensions, centered on the determinants of health inequities. The difference between these approaches as will be seen subsequently is on their scope and complexity as well as their capability to establish strong and permanent links between actions and social and economic development plans.

The appropriate definition of the problem contributes to defining the nature and scope of these strategies, as well as the mechanisms and resources that guarantee an implementation in line with needs, expectations, and territorial context. Territorial development plans must be coherent with the cultural and sociopolitical context of each region, revealing through them the philosophical and political orientation that underlies any option chosen. With different paradigmatic perspectives, intervention models cannot be subjected to the same mechanism of valuation, validation, or application, as usually happens under so-called good practices, without taking into account the context.

Although there are differences between the three strategies, they do complement each other. PHC, HP, and HiAP, rather than theoretical formulations, are philosophical and political positions about health expressed in governmental and social strategies and programs.

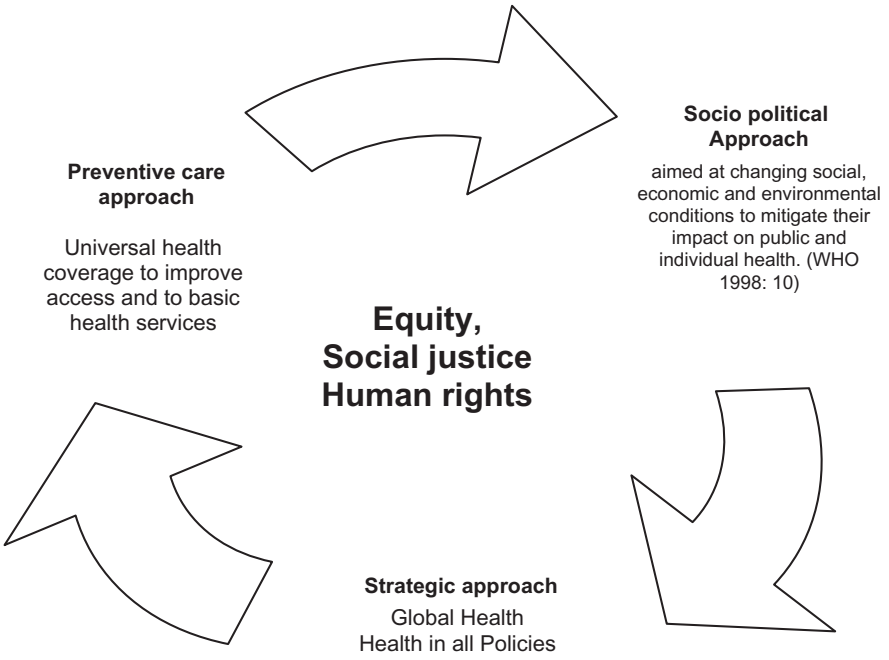

Fig. 2.1 Main focus of strategies to address health inequities (Source: authors' elaboration)

The strategies (PHC, HP, and HiAP) differ in, among other things, their origin, scope, actions, actors, application scenarios, results, and impacts. The analysis of these approaches, as indicated earlier, represents a valuable input to monitor, value, and strengthen processes of change. A critical and contextualized discussion of the approaches and their implementations will show that they are connected and complement each other. Hence, it is necessary to integrate them in order to act in a coordinated manner, taking into account their differences, scope, and requirements for their application.

Figure 2.1 shows different strategies oriented to the search for equity in health, social justice, and human rights, differentiating them by their origin, scope, actions, actors, and results, among other factors. The analysis of these approaches constitutes a valuable input to coordinate, monitor, and evaluate the processes of change and results.

Different authors define the scope of these strategies from two perspectives: one perspective focuses on risk factors associated with behavior, lifestyles, and access to basic care consistent with the notion of free choice; the second focus emphasizes the determinants of health, specifically the determinants of inequities (structural). Emerson (2013:1499), regarding health inequities, said, "Some health disparities may be attributable to biological variations or free choice. Others may

be attributable to environmental conditions beyond the control of individuals concerned. In these instances, the uneven distribution of health may be considered unnecessary, avoidable, unjust, and unfair."

The three strategies aimed at reducing health inequities (PHC, HP, and HiAP) represent a social policy approach, each of which, as already indicated, acts on different aspects and levels of complexity. It would not be an exaggeration to say that each one is a response to the degree of progress, results, and gaps that preceded it. This permanent renewal has taken place in the theoretical dimension, and very little in the practical realm. Hence, it has not necessarily been useful to close gaps between and within countries, such as in the results, impacts, and capacity of responses to satisfy the demands implied by their application. The reorientation of services would seem to be the strategic bridge for transforming health systems, oriented to the health promotion of (glimpsed from Ottawa, Canada); politics, its substantial element; and the sempowerment of the community, is the driving force behind the action. In addition, in neoliberal times the change in the sense of the public (need to build "public value") is an obligation to fill the gap (Franco-Giraldo 2009).

What follows is a description of what has been the practice of the strategies (PHC, HP and HiAP), based on their theoretical definition, scope, complexity, and practical meaning. Although the analysis of each strategy was done separately, it is necessary to take into account that the factors that have facilitated or limited their implementation are common to all, based on the territory where they are implemented.

Universal Coverage Through Primary Health Care

The definition expressed in the Declaration of Alma Ata (1978) considers PHC to be "an integral part of both the National Health System, from which constitutes the central function and the main nucleus, and of the overall social and economic development of the community." International evidence suggests that health systems organized based on strong PHC orientation achieve better and more equitable health outcomes, are more efficient, have lower costs of care, and achieve higher user satisfaction compared to systems that have a weak PHC orientation.

According to Apráez (2010:370), "the history and development of primary health care and Health Policy for All in 2000 do not originate from Alma Ata (Litsios 2002:17) but have roots in 'social medicine' with the movement led by Rudolf Virchow and Jules Guerin, among others (Waitzkin 2006:31)." PHC is also considered a movement that competes with a set of diverse actors with activities directed to the promotion of broad citizen participation (Rojas Ochoa 2003). For Franco-Giraldo (2012) "PHC is an operational strategy (currently a world policy) needed to make urgent changes in health systems." Barten (2012), regarding the scant explanation of PHC, makes the following observation:

> The lack of a common and shared vision of the meaning and purpose of PHC was/is a great challenge. It has been suggested that a solution might be to insist that the use of the PHC concept should always be followed by a clarification of it: level, program, strategy or philosophy. (2012:349)

The WHO (2003) document states that PHC evolves according to the economic, sociocultural, and political characteristics of each country. Although there is not a single operational definition of PHC, there are nonnegotiable principles as well as mechanisms that should help to create the conditions for compliance with them. This raises several questions: Is it appropriate to expect a reproducibility of results? To use similar indicators to assess progress and results? To refer to the needs of the development of a research and work agenda aimed at strengthening theory and practice in a dialectical, ontological, and transformative way? PHC, HP, and HiAP depend on the possibility of working in politics and making use of power. The results, therefore, are highly influenced by the redirection in the use of power in the world and the implementation of a series of local strategies within the framework of globalization (glocalization).

WHO (2005), citing several examples, argues that the increase in coverage follows a movement that goes from being a typical situation of mass deprivation (low coverage for all, except for high social strata) to a state of marginal exclusion (high coverage for all groups except those in the lowest socioeconomic stratum). Previous results were repeated in later studies. According to the authors, these results warn about universal coverage, which is not achieved easily and in a short time. In developing countries, despite significant progress, universal coverage has not been reached in the 30 years of Alma Ata.

On the other hand, Franco-Giraldo (2012:198) affirms that to achieve population-wide health, the reorientation of services is the means, PHC is the strategy, and population health is the general framework for action; however, some authors point out the advantages and limitations of this approach and the reasons why it have become a constraint rather than a facilitator of health equity. The Brazilian experience is examplary; an inverse hypothesis has emerged in regard to equity, and it argues that new programs initially cover people with high status, and sometime later it reaches the poorest. The preventive care approach is especially represented in the PHC strategy, although in recent decades its scope has been expanded with the so-called renewed primary health care (2007). Therefore, the authors concluded that there is little reason to believe that working on universal coverage will lead to improvements in health equity. Progressive universalism is the alternative proposed by the authors, who observe two initiatives from Brazil and Mexico: Brazil's Family Health Program (1994) and Mexico's Popular Insurance initiative (2004). In both, the program began in the most depressed territories and social groups and was applied progressively in other precarious areas. The premise in the proposal is that groups with greater disadvantages at least earn the same as those who are better off at each stage of universal coverage.

Very important advances have been made in PHC within the health system, as mentioned earlier, but to assert that this is due to global economic development is to grant PHC a scope that is far from the reality, for the reasons noted earlier. In response to the lag in accomplishing some objectives, so-called renewed PHC was created, whereby new responsibilities and challenges are theoretically assumed to correct past mistakes, but it continues to operate within the system and structures that have been the main cause of limitations and current gaps. In this sense, Franco-

Giraldo (2009) posed the following questions: What is being renewed from the PHC? More specifically, what should be renewed? The theoretical definition of PHC has evolved, making its implementation more complex. Reference is made to intersectoral actions, the involvement of development sectors and actors, strengthening the participation and self-determination of the community in the planning, organization, operation, and control of available resources, as well as the use of integrated reference systems, which are functionally supported and give priority to the most vulnerable populations. As we will see subsequently, these actions are also present in the HP and HiAP strategies, meaning there is an urgent need to generate processes of change in the structures, mechanisms, and resources in which these strategies develop their full potential.

Health Promotion: A Sociopolitical Approach

A critical look at the fundamentals, advances, and factors that influence the performance of HP will provide inputs to generate proposals that lead to the strengthening of its theory and practice. PAHO in its online publication (2005), quoted by Muñoz and Cabieses (2008), reaffirmed the procedural nature of HP. The political approach was highlighted as it enables the transformation of existing structures. The scope, complementarity, and complexity of HP can be summarized in the definitions of Ottawa and Jakarta; it also shows the following complementary aspects:

> Health promotion is a process ... that addresses complex health, social and economic problems, and provides a valuable framework to organize social and political action in order to improve health and living conditions. Health promotion is therefore a technical, political, social and academic approach to work with different sectors and improve the quality of life of people. (2008:141)

Table 2.1 describes the conception and some requirements for implementing operate HP initiatives, according to different authors. Although the table does not present all valuable theoretical and practical contributions, it accounts for the key issues and scope given to this strategy that are in some way necessary to implement other, related strategies. A central aspect that we want to highlight is the diversity and breadth of approaches that are based on different conceptions of health and on the evolution and complexity of forms and contexts where health is promoted and modified. This fact also explains the diversity of interventions to implement HP that are linked to the characteristics of the contexts and scenarios of practice. So that there is no single metric or standardized lists of criteria that represent this diversity, what should exist are guidelines that must be adapted to each site and process of improvement. An important, but usually neglected, issue is analyzing the implications and elements of these strategies that need to be in place for these strategies to work. This is precisely where the monitoring and evaluation indicators should be centered. Many of the aspects mentioned in the column of implications are widely known, so we present some implications of these concepts in practice as examples; but this is an exercise that must be performed in each territory or practice scenario.

Table 2.1 Health promotion conceptions and approaches

Definition and scope	Reference	Implications
For the international community health promotion is understood to be (1) a function of public health, (2) a practice, (3) a strategy, (4) a social movement, and (5) a process HP has been defined, sometimes indistinctly and without internal coherence, as a dimension, a strategy, a process, or a set of actions	Mark et al. (2000) Eslava-Castañeda (2006:7–9) Quesada Monge and Picado Herrera (2014:129)	Relational field of action that includes instances of social participation (strengthening of community activities, inclusion of civil society) Coalescence of a perspective that focuses on the elaboration of guidelines according to the execution of specific and efficient actions
HP constitutes a global political and social process, embracing not only actions aimed directly at strengthening the abilities and capacities of individuals but also those aimed at changing social, environmental, and economic conditions in order to mitigate their impact on public and individual health It addresses complex problems and provides a valuable framework in which to organize social and political action in order to improve health and living conditions HP is a technical, political, social, and scholarly approach to working with different sectors and improving the quality of human life HP is a process that enables people to control their health in order to improve it by acting on the determinants of health to create the greatest health benefits for people, to make significant contributions to the reduction of health inequalities, ensure human rights, and build social capital	WHO (1998:10) Sapag and Kawachi (2007:144)	Global political and social process requiring structural reforms of vertical/horizontal ordering Concrete structures, but flexible enough to allow for the dynamism of the context Appropriate structures and legislation for the implementation of intersectoral strategies, so individuals and civil society can have greater control over health
A strategy and a social movement, field of knowledge, scenario of action, and "methodological practice of current or international movement"	Chapela (2001) in Díaz-Mosquera et al. (2015:34)	Oriented to social and political actions; it is permanent, therefore sustainable
Provided to people by the necessary means to improve their health and exercise greater control over it		Demands an appropriate long-term and sustainable process supported by structures and resources for the implementation of intersectoral strategies
HP in practice should be a product of alliances between different bodies responsible for its development Research and academic centers, governments, society, and international collaborative health agencies, among others	De Salazar (2009:40–41)	The alliances should integrate or articulate not only sectors but fields of knowledge as well as political and social actions Interdisciplinary and transdisciplinary approaches must be consolidated to achieve greater and timely achievements without redoubling efforts between sectors

Community effort directed to … the education of individuals in the principles of personal hygiene … the development of the social machinery to ensure each individual in the community a standard of living adequate for the maintenance of health	Robledo-Martínez and Agudelo-Calderón (2011:1035)	Alliances with academic institutions; innovative training approaches of different stakeholders to meet goals; reorientation of power relations between partners and participants in working teams; redefinition of scope and responsibilities of institution, sectors Transdisciplinary approach to develop and socialize health issues, in an integral way, based on three systems of knowledge: scientific, individual, and collective
Most of these strategies should have the territory as their setting and a scenario of negotiation and practice (territorial identity) Adoption of foreign models, after studying their relevance and territorial feasibility, taking into account cultural, social, political, and economic characteristics of the territory	De Salazar (2011:19–20)	Adjustments and adaptations of the international guidelines to the particular Latin American realities Alignment of sectoral plans with territorial ones through common objectives, financing, and articulation of working areas to fulfill objectives Policies, legislation, regulation, and mechanisms to strengthen intersectoral actions, with autonomy and active social and community participation in territorial agendas
The strategies must be monitored, understood, visualized, and revitalized to account for the relevance, performance, and coherence of transformative territorial processes	De Salazar (2011) De Salazar (2012:43)	To address structural causes policy, geographic, organizational actions. The processes of change, in this way, would focus on intervening causes of inequities rather than on their consequences. This characteristic differentiates these interventions from other risk prevention and disease care. In this way, processes of change and transformation are more sustainable The question is how a fragmented and service-oriented health sector can contribute to changes in raising the level of education, promote policies to guarantee equity access to opportunities and goods, improve food and nutrition, and increase access to safe employment and dignified income
The existence of a new logic of HP, oriented to the social sphere, which is synthesized, according to the authors, by five strategic lines: elaboration of healthy public policies, strengthening of social participation, strengthening of individual and collective skills, creation of healthy environments, and reorientation of health services	Quesada Monge and Picado Herrera (2014:130)	Social logic complementary to traditional health actions; action based on lessons learned from practice, supported by a sustained process of learning and capacity building

In an effort to synthesize HP definitions formulated in different studies, Eslava-Castañeda (2006) identified three different but complementary meanings. First, it is an international health policy that seeks to intervene in lifestyles and conditions that in a way that enables individuals to make healthier choices. Second, HP is a set of actions and processes designed to help communities and individuals exercise greater control over the determinants of health, thereby maintaining or improving their "health condition." Finally, health is conceived as a positive state, and not disease, so actions are focused on maintaining health conditions and ensuring the well-being of individuals and populations (2006:108).

> It is difficult and sometimes unwise to pontificate about the core values of health promotion, but since most nations at least pay lip service to the canons of the World Health Organization, we may confidently identify the following key values: Health is holistic and not solely concerned with disease and its prevention; health is about equity and social justice; and health is about empowerment (Tones 2005:27).

The Ottawa Charter (WHO 1986) promulgated a set of HP actions that have been gradually adopted and adapted in Latin America. It is important to highlight that these actions are permanently reinforced around the generation of public policies in favor of health and well-being, the creation of support environments in the territory, the reorientation of services, the responsible and coordinated participation of other sectors around health and life conditions, and the strengthening of local capacity to address challenges related to the social determinants of health. The close relationship between equity, well-being, and health led to the emergence of new approaches integrating economic and social dimensions more tightly. In 1991, the World Bank supported the reinforcement of the principles incorporating the issue of economic and social development as an extrasectoral component of health.

Healthy lifestyle[1] and the ability to enhance human development, according to Quesada Monge and Picado Herrera (2014:137), have been identified as dominant theoretical-methodological approaches in HP. The first approach, associated with the behavioral modes of individuals based on self-care and the various kinds of socialized and internalized knowledge. The responsibility of promoting these lifestyles falls on the institutions providing health services; however, the intentionality of engaging in healthy actions entails complex operational logics whose effectiveness depends on the viability of intersectoral work and the political wills that

[1] De Salazar (2012:6) emphasizes that "the vast majority of studies on health promotion have been presented at national and international events, focus on approaching lifestyles, dying, with very few giving an account of the social determination, its effects on the health conditions of the populations and the impact and effectiveness of the responses."

generate certain social and economic conditions. The second approach aims at strengthening human talent and its development and community participation, through which an effective balance of power relations is achieved. This last approach was proposed in the Declaration of Santiago 2016, as a means to effectively address equity in health.

Key aspects of the strategies and how they emerge from the most holistic conceptions of health are theoretically complementary, but efforts are needed to integrate them into territorial systems and structures. Instead of competing, they should be mutually supportive and reinforcing so they do not end up redoubling each other's efforts. Likewise, it can be said that each new strategy, besides pointing to theoretical advances in addressing health inequities, is a reflection of the failures of previous ones. Thus, understanding the causes of success or failure is mandatory so that the mistakes of the past are not repeated and present opportunities are seized. It is important at this point to analyze the influence of globalization and international policies and guidelines, as well as national policy systems of operative HP definitions. It is striking that many drawbacks of policies are found in both developed and developing countries.

One common problem, mainly in LMICs, is that traditionally governments do not usually prioritize health among their political objectives. Beyond improvements in health services, actions relating to the transformation of living and working conditions and knowledge leading to sustainable well-being processes are not part of a country's political agenda.

In addition to structural and functional changes in state institutions and civil organizations, permanent, active, and informed participation of the population is required. The question is whether a given type of participation meets these criteria or whether, on the contrary, it is an instrumental, reactive, conjectural, and sporadic type of participation. Likewise, it is necessary to reflect on whether there are organizational and functional structures that favor the fulfillment of these criteria and contribute to equally balance the power relations within the different forms of participation in localities.

> (Díez et al. 2016:76) argue that the concept of "causes of causes" is poorly understood by authorities, the general population, and even public health staff. Society is mobilized by and for care resources, and hence the absence of preventive public policies is not the object of popular demand.

Health in All Policies: A Sociopolitical Approach at a Higher Level

The roadmap document for the Plan of Action on Health in All Policies (PAHO 2016) recalls that the HiAP "was defined for the first time in the 2010 Declaration of Adelaide and, subsequently, it was presented in a global framework for action in

the countries in the Helsinki Declaration of 2013." HiAP is understood as a political strategy and practice directed at encouraging a greater political commitment to achieve structural transformations for health equity.

> Health in all policies is the political practice aiming to include, integrate or internalize health in other policies that shape or have any influence on the SHD.….Health in all policies focused more in the "large issues" and less in those programs or individual projects. Depending on the institutional context of each country, these political practices can start at the national, regional, local level, or even distributed in the different levels of government. The political practice "requires a form of governance in which there is a joint leadership between governments, between all sectors and between different levels of government." (Adelaide Agreement 2010 in McQueen et al. 2012:15)

To identify, analyze, and intervene to reduce health inequities, it is necessary to dig into the deeper causes interwoven in the fabric of society and the mechanisms of human biology in clinical aspects related to the way people cope with disease and disability. In the nineteenth century, wherever there was observed a combination of critical epidemiological thinking, availability of health data, and well-organized public health movements, there emerged a growing interest in the social, physical, and biological causes of epidemic diseases (Beaglehole and Bonita Diderichsen 1997 et al., in Evans et al. 2002:13). In the context of the eight World Conference of Health Promotion (PAHO 2016), HiAP is defined as "an approach for all the public policies and sectors involved in decisions that affect equity and health conditions." These policies take place at national, regional, local, or even distributed in different levels of government.

Some Considerations for Reflection

It is important to highlight two aspects of the foregoing definitions: (1) the responsibility for a strategy's implementation is placed with the health sector/national health systems; (2) the strategy's relation to social and economic development processes must be clearly articulated. In the first case, it is has been observed that reforms of health systems are not always in line with the necessary changes for an appropriate implementation of the given strategy, and even less has the strategy's relation to economic development processes been articulated, given the lack of plans and agendas commonly associated with territorial development. Most regional reports and publications reflect this problem, as will be shown subsequently.

A country's response to a previous situation can be to make minor changes that do not represent threats to the power structures, much like following the guidelines of cooperation and financing international agencies, whose agenda has been formulated with insufficient participation of countries (differential participation). This is not to say that the participation of these agencies is bad or good; rather, these agencies also reflect the imbalance of power relations and the effects of globalization. Such a situation requires that regions, countries, and populations be

given the capacity to argue for and defend their policies in a way that is more in line with the needs of their inhabitants. In this manner, people can not only take advantage of the opportunities offered but also participate in the construction of agendas that affect them.

There are undeniable theoretical developments and contributions that can be applied to strengthen existing strategies (renewed PHC) or formulate new strategies to fill the gaps left by previous ones. However, we must ask ourselves on the following questions: What is the capacity of our country/region to respond to the challenges of a strategy's implementation? What is the coherence between the international and national agendas and our reality? What are our country's priorities? The clarity and depth that will come from reflecting on these questions will be valuable inputs to reorient practice, research, policies and programs, and, especially, operational plans (priorities and funding).

Although the experiences related in what follows do not represent the situation of all Latin American countries, they give an idea of the topics of interest, as well as the advances achieved and limitations that have had to be overcome in practice. As can be observed, there are differences in the presentation and depth of the cases, although the format of the questions was designed to allow standardization the contents of the reports. It is understandable that the directions given could be difficult to follow because the particular experiences were in different stages of development.

Key aspects for addressing health inequities were explored, comparing theory and practice through an analysis of international guidelines and advances in the "real world." One of these aspects is related to intersectoral work, which is behind the strategies studied in this publication. The countries belonging to the Latin American and Caribbean Network for Health Promotion were invited to participate; not all of them responded, but one of the members presented the experience of the network. In addition, experiences were presented from Brazil, Peru, Mexico, and Colombia. What follow are some of the questions addressed. At the end a critical analysis and lessons learned will be presented.

Are There Ongoing Intersectoral Initiatives?
Description of intersectoral initiative
How, when, and why did it arise?
What advances have been made? What is the time horizon?
What motivates such initiatives?
What situation motivated intersectoral work?
Who are the partners? What responsibilities do they have?
What equity issues were addressed?
Were inequity aspects taken into account in the formulation of the problem?
Did the intersectoral work take place in the intervention planning, only in practice, or in both?

A sample of the questions follows:

Key Aspects of International Guidelines for Developing and Operating Intersectoral Initiatives
Are the international guidelines on intersectorality taken into account?
How much?
What factors have helped/limited their implementation?
Have changes been made to the initial intervention design to address difficulties?
What changes have been made or should be made?

Rebuilding the Practice as a Learning Tool to Strengthen Territorial Capacity to Increase the Feasibility, Effectiveness, and Impact of Interventions

In the previous section, we pointed out critical aspects related to the implementation of strategies aimed at reducing health inequities, and we highlighted the fact that whatever the name of the strategy for addressing this problem, it is necessary to strengthen the territorial capacity (community, institutional, governmental, civil society) to ensure its success. The need for a holistic health approach is another condition; this means a delimitation of the problems and priorities, transcending the clinical perspective, as well as operational approaches consistent with the context (available structures and resources) and, more importantly, putting in place sustainable processes for the permanent strengthening of the capacity to analyze, understand, and transform reality. In this way, practical experience becomes an element of transformation and capacity building. Several concerns arise about "know-how" and the sustainability of these processes.

There is an extensive literature on what needs to change; the challenge is precisely how to achieve it, an consideration that is absent in most publications. This means that, although we are aware of key requirements for carrying out interventions, we cannot be certain that they will be applied because in most cases they are not documented. Governments, as well as funding and international cooperation agencies, have contributed to this situation because most of them emphasize results rather than the process and mechanisms that make results possible. The political and social nature of transformation processes reminds us that these processes are not static and so do not operate in all contexts. The question that emerges from this fact is this: What, how, and when is it appropriate to standardize interventions? There is no doubt that there is a lot of information on what, but very little about how, especially for developing countries. The answer has many facets, so we will not provide a final answer on these issues, but arguments will be provided to build one.

The theoretical concepts could probably be generalized to a certain extent, but not their implementation, which is circumstantial and contextual. The last aspect incorporates and defines the type and importance of the relationships and interac-

tions between the different living forces in the territory and their structural components (e.g., society, culture, organization, communication, power relations, social class, socioeconomic factors, and physical resources). These and other concerns will be the subject of further analysis. Likewise, "the know-how," for reasons of "contextual identity" mentioned earlier, should not necessarily be replicable in all contexts without first making an analysis of the assumptions and conditions that guarantee its applicability. We do not use the term *identity* capriciously, but in defense of a conception of territory, as a social construction with relationships, interactions, relations of power, values, history, and culture within it.

To motivate this analysis, we requested the voluntary participation of institutions and researchers involved in health promotion interventions, mainly those aimed at reducing health inequities. A flexible guideline was shared with those who agreed to participate, and the key issues will be covered (see attached format). Despite this request, not all participants provided the expected reflection but discussed the advances in their work.

As stated earlier, we are aware that the experiences reported do not represent all Latin American countries, which is why we furnish a brief description of the main results found in most representative studies, such as the *State of the Art* and *UNASUR* studies (De Salazar 2012), both of which addressed HP interventions in Latin American countries.

Background

A number of studies have been carried out containing information and evidence on the burden of disease and risks of contracting diseases from a biomedical perspective; however, there is scant information about real problems and the interventions used to deal with them. In addition, information on the interaction of factors arise within the framework implementation of interventions and contribute to the results and effects. No one study mentions which groups felt the effects more acutely or not at all, those that experienced differential effects, those who benefited most/least from the interventions, or, finally, the structures and mechanisms that contribute to the accessibility of opportunities and services. The evaluative studies reported in the UNASUR region (De Salazar 2012) present partial evaluation results focused on problems related to disease and risk events from a disciplinary and sectoral perspective. These evaluations emphasize the performance of programs in terms of compliance with scheduled activities, without interpreting this information in the light of the specific context and circumstances in which the findings were obtained. Theoretically, primary health care and HP strategies demand changes in the structures that historically have influenced the implementation of interventions to fulfill the two principles mentioned earlier (the right to health and equity).

It is striking that, although there is continuity in the work deployed in fields closely related to health promotion, these findings are not treated as actions of HP because they develop outside the health sector. This is the case of public policies for the reduction of poverty and improvement of access to education, housing, and

employment. The evaluative proposals reflect large gaps in concepts, theoretical and methodological approaches to assessing other aspects that directly influence outcomes, such as the quality of the intervention design according to intentionality and objective, the performance, and the methodological approaches to valuing the effectiveness and impact of these interventions (De Salazar 2012).

This indicates the limited scope of evaluation and indicators to account for equity and social determination in health. Likewise, it shows that there are insufficient inputs to use the results of evaluation in strengthening the theory and practice of policies and programs. The promoters of these initiatives recognize gaps in the theoretical foundations, the context, and the processes for the implantation and implementation necessary for the achievement of objectives. With their high social and political content, most interventions in HP have their own dynamics, not necessarily reproducible. There is also no record for monitoring and evaluation processes or, more importantly, the use of this information to strengthen or reorient interventions (De Salazar 2012). The situation described exists in several countries, and LMICs are not the exception, as reported in the following studies.

> Burlandy (2009) and Jorquera (2011) describe the influence of health systems management on interventions; Carmichael et al. (2012) identify barriers and limitations to integrating sectors and agendas in a territory. Grundya et al. (2009) compare current health needs with the relevance of health system responses. Sosa et al. (2013) believe that health planning should incorporate other sectors. Castell-Florit Serrate and Abreu (2012) find that the identified sectors were different compared to what evidence shows (2012).

In summary, a significant volume of studies focus on the justification of advances concerning the reduction of the magnitude of biological-clinical problems in order to justify interventions. A very brief description was given on how changes have been achieved, and in a few cases the results were attributed to intervention. This, in practical terms, means that the analysis of the advances is not contextualized according to each scenario, in an attempt to unveil and understand the main factors "responsible" for the results.

Additionally, programs in which actions fall outside the scope of the health sector were not considered. Although it is not possible to cover all subjects in sufficient depth, we hope that this exercise will allow the identification of areas that require further analysis. As mentioned previously, the recipients of this publication are government workers, civil society organizations, civil servants, and agencies of cooperation and financing of Latin American countries. A public, relatively homogeneous with respect to the need and challenge to comply with international strategies to reduce social and health inequities but heterogeneous in many respects such as capacity, forms, and mechanisms to adapt or reformulate actions in favor of equity, social justice, and the exercise of rights, three closely related aspects.

An outline was developed to guide the construction of cases that focused on practice as a learning tool, strengthening the production of territorial capacity, increasing the viability and effectiveness of interventions (see appendix, Table 2.2).

Appendix

Table 2.2 Interventions aimed at reducing inequities in health

Intervention: Policy/program/project/strategy		Observations according to list of questions
Rationale of formulation of problem intended to respond with intervention	The types of health inequities that have been identified and their consequences must be modified or reduced by: Context: Socioeconomic, political, demographic, and geographical characteristics of the territory Inequities underlying health inequalities Which social groups or more vulnerable clusters (ethnic minorities, women, children, the elderly, the disabled)? Potential causes (social, economic, cultural, environmental)	The nature of the problem: Who participated in defining the problem (government institutions, civil society, church)? Who is a problem for? Who is most affected? Is the formulation of the problem clear and complete? What information and evidence (type of evidence: scientific (analytical, documentary) or testimonial) were available to define the problem? What is the probability of being modified?
Type and scope of intervention Results	Explain what the intervention consists of: Background: Description of context of intervention considering information available on aspects that in the opinion of those responsible and beneficiaries of the intervention could influence the implementation of intervention and the results, taking into account components: historical, political, geographical, demographic, social, cultural, and economic. Different tensions that have arisen in the past but are influential in the present and determinants for the future welfare of a population, in a negative scenario with populations that are not empowered in any dimension. Design of intervention: Justification: Why and how did the intervention arise? Who determines the need for its execution? Actors involved: state, civil society, private Desired change: conjunctural situation, chronic, structural, or a momentary solution What results/impacts are expected? (Short, medium, or long term) What kind of indicators are used to measure success? Theoretical framework Theoretical support References to successful or failed studies that help in the identification of key elements in intervention planning through a strategic design to implement properly Strategies Indicators of success (by process stages, results, for the indicator of impact the reduction or of the prevalence, for example) Objective(s) Describe the general and specific initial objective and whether it changed Operational plan for implementation: Identification of factors favoring and limiting the results Which sectors, institutions, NGOs participate and in what capacity? Factors that could influence the results obtained Identification of primary and secondary data sources: people, institutions (e.g., records of organizations, government and welfare institutions, community registries, information systems)	(Preevaluation of design or planning of institutions, actors, and resources involved in the process) How the intervention is defined: Scope, relevance, and consistency with the problem: Population, focused Levels (individual-family-community, territorial) Sectors: Rural and urban (feasibility, budget, area recognition, previous immersion) Approach (sectoral–intersectoral) Time horizon Is the theoretical framework of the intervention based on evidence from studies with similar objectives and conditions? Is the intervention guided by strategies such as APS, SeTP? (Emphasis) What guiding principles and components of previous strategies were considered? Who is most interested in this intervention? What interests you? Was a theoretical framework worked out to support the design of the intervention? Where does it come from? International, national, and local guidelines Were these guidelines adapted to the conditions of the territory? Has the objective of the intervention been properly defined? Is it achievable? (viability) Do the specific objectives meet the general objective? Did they change? How does it take to meet the objective? Were consideration for the design aspects of the context that could influence both the implementation Strategic/operational plan Was an operational plan formulated to implement the intervention? Was the plan monitored? Were the planned activities developed? If not, why did this situation arise? Was the change process documented? Were the resources identified according to sufficiency and relevance for carrying out the proposed activities? Were the assumptions made explicit for the intervention to work? Are the key actors of the intervention explained? Functions, times, resources?

(continued)

Table 2.2 (continued)

Intervention: Policy/program/project/strategy		Observations according to list of questions
	Expected results according to the degree of implementation Were monitoring and follow-up included in the implementation process? Was it participatory? Were the views of potential beneficiaries taken into account? Identified progress: strengths and limitations? Were the main factors favoring and hindering implementation identified? Critical analysis of process and results (final/intermediate) Were they expected? Did they get additional? Were links established between problem, intervention, and results? Did the formulation of indicators take into account the nature and scope of the intervention? The time to produce the expected results? Performance during the intervention? What and for whom? How should the approximate results be presented to decision makers? What key aspects should be weighed in the context of this presentation? What would you change about the intervention to achieve the expected progress? Are they satisfied with what has been accomplished? What is missing? Why did it not happen? Lessons learned from this analysis: Aspects that contributed to or limited the accomplishment of activities and achievement of the objective, especially the components of the strategies to reduce health inequities: Political Economic Social Cultural Infrastructure Legislation and regulations Capacity Did the professionals who participated in the intervention meet expectations, or are professionals from another area or field required for subsequent interventions in order to complement aspects not developed?	Are indicators clearly identified and defined to assess the success of the intervention: design, implementation process, effectiveness, and impact? Do the indicators respond to the objective and nature of the intervention? Is the relation between problem/intervention/expected results taken into account in the analysis of the results? Was the influence of the time variable on the results analyzed? Was the increased dollar variable, its price fluctuation compared to what was presupposed in an initial stage of the proposal and its lag before the intervention, taken into account? If not, there will be a budget shortfall Were monitoring and evaluation protocols followed? Was the intervention implemented as planned? Have aspects such as objective, subject population, time, resources, and strategies been adjusted in the course of the intervention? (Imponderables of nature, climate change, accessibility) What should be changed? Why? If the intervention were repeated again, what would it change and why? Were the reasons for success/failure collectively analyzed? Was this information used to establish corrective measures? Were the initial assumptions met to achieve the objective of the intervention? What key players participated in the intervention and how? Current/available information Did the group analyze the feasibility of meeting the objective in the light of changes in the results, context, and conditions under which the intervention was implemented? Concluding remarks about: Relevant theoretical reasoning/insufficient Structures (required) Priority: low/high; for whom? (resource sufficiency in terms of quantity and preparation) Legislation—normativity Contribution of information systems, monitoring and evaluation, and type of intersectoral management Performance of strategies related to intersectoral action and participation and empowerment of actors; balance of power relations; sustainability

Suggested scheme for construction of cases

References

Apráez IG (2010) La medicina social y las experiencias de atención primaria de salud (APS) en Latinoamérica: historia con igual raíz. Polis de la Univ Bolivariana 9(27):369–381

Arellano OL, Escudero JC, Carmona LD (2008) Los determinantes sociales de la salud. Una perspectiva desde el Taller Latinoamericano de Determinantes Sociales de la Salud, ALAMES. Medicina Social 3(4):323–335

Barten F (2012) Comentario sobre investigación en sistemas de salud, atención primaria de salud y participación para la transformación social. Saúde em Debate 36(94):348–351

Busso G (2005) Pobreza, exclusión y vulnerabilidad social. Usos, limitaciones y potencialidades para el diseño de políticas de desarrollo y de población. VIII Jornadas Argentinas de Estudios de Población (AEPA). Tandil, Provincia de Buenos Aires

Caicedo-Velásquez B, Álvarez-Castaño LS, Dell'Olmo MM, Borrell C (2016) Evolución de las inequidades en mortalidad por causas externas entre los municipios de Antioquia (Colombia). Gac Sanit 30(4):279–286

Caribbean Latin America Economic Commission (ECLAC) (2003) Inequidad, ciudadanía y pueblos indígenas en Chile. CEPAL, Santiago de Chile

Caribbean Latin America Economic Commission (ECLAC) (2015) Panorama social de América Latina. ECLAC

Caribbean Latin America Economic Commission (ECLAC) and the group of the United Nations for the development—Latin América and the Caribbean (UNDG LAC) (2013) Desarrollo sostenible en América Latina y el Caribe Seguimiento de la agenda de las Naciones Unidas para el desarrollo post-2015 y Río+20. United Nations

Chossudovsky M (2002) Globalización, pobreza y nuevo orden mundial. Siglo Veintiuno Editores, Argentina

Clavier C, De Leeuw E (2013) Health promotion and the policy process. Oxford University Press, Oxford

Cruz Ferré J (2016) Economic inequalities in Latin America at the base of adverse health indicators. Int J Health Serv 46(3):501–522

Daulaire N (2003) Beyond trade: taking globalization to the health sector. New Solution 13(1):67–71

De Leeuw E, Green G, Kickbusch I, Palmer N, Spanswick L (2014) Policy and governance. In: De Leeuw E, Tsouros A, Dyakova M, Green G (eds) Healthy cities. Promoting health and equity—evidence for local policy and practice. World Health Organization

De Roux G (2008) Hacia un Valle del Cauca incluyente y pacífico Informe Regional de Desarrollo Humano IDH-Valle. PNUD, Bogotá

De Salazar L (2009) Efectividad en promoción de la salud y salud pública: Reflexiones sobre la práctica en América Latina y propuestas de cambio. Programa Editorial Universidad del Valle, Cali

De Salazar L (2011) Reflexiones y posiciones alrededor de la evaluación de intervenciones complejas. Programa Editorial Universidad del Valle, Cali

De Salazar L (2012) Abordaje de la equidad en intervenciones en Promoción de la Salud en los países de la UNASUR. CEDETES, Cali

Díaz Mosquera SP, Rodríguez Villamil LN, Valencia González AM (2015) Análisis de publicaciones en promoción de la salud: una mirada a las tendencias relacionadas con prevención de la enfermedad. Rev Gerenc Polít Salud 14(28):32–47

Díez E, Avinó D, Paredes-Carbonell JJ, Segura J, Suárez Ó, Gerez MD, Pérez A, Daban F, Camprubí L (2016) Una buena inversión: la promoción de la salud en las ciudades y en los barrios. Gac Sanitaria 30(S1):74–80

Emerson E (2013) Health disparities. In: Encyclopedia of autism spectrum disorders. Springer, New York, pp 1499–1500

Eslava-Castañeda JC (2006) Repensando la Promoción de la Salud en el Sistema General de Seguridad Social en Salud. Revista Salud pública 8(2):106–115

Evans T, Whitehead M, Diderichsen F, Bhuiya A, Wirth M (eds) (2002) Desafío a la falta de equidad en la salud: de la ética a la acción. PAHO, Washington, DC

FAO-ONU (2015) La FAO y los 17 Objetivos de Desarrollo Sostenible. Roma, Italia

Franco-Giraldo Á (2009) Atención Primaria en Salud (APS): ¿De regreso al pasado? Ponencia en el 6° Congreso Internacional de Salud Pública, Facultad Nacional de Salud Pública. Centro de Convenciones Plaza Mayor, Medellín. Consultado 12 de septiembre de 2009

Franco-Giraldo Á (2012) Promoción de la salud (ps) en la globalidad. Facultad Nacional de Salud Pública 30(2):193–201

Franco-Giraldo Á (2016) Salud global: una visión latinoamericana. Rev Panam Salud Pública 39(2):128–136

Frenk J, Gómez-Dantés O (2007) La globalización y la nueva salud pública. Salud Pública 49(2)

Grupo Banco Mundial & Fondo Monetario Internacional (2015) Informe de seguimiento mundial 2015/2016. Los objetivos de desarrollo en una era de cambio demográfico. Grupo Banco Mundial & Fondo Monetario Internacional

Informe de Progreso Económico y Social (IPES) (1999) IPES 1998/1999: América Latina frente a la desigualdad. Grupo Banco Mundial y el Fondo Monetario Internacional

Kay A, Williams O (2009) Introduction: the international political economy of global health governance. In: Kay A, Williams O (eds) Global health governance crisis, institutions and political economy. Palgrave Macmillan, Basingstoke

Korzeniewicz RP, Smith WC (2000) Pobreza, desigualdad y crecimiento en América Latina: en búsqueda del camino superior a la globalización. Desarrollo Económico 40(159):387–424

Kovačić N (2014) Globalization and the impact of globalization on the health industry. Interdiscip Manag Res 10:684–695

Litsios S (2002) The long and difficult road to Alma Ata: A personal reflection. Int J Health Serv. 32(4):709–732

López Segrera F (2016) América Latina: crisis del posneoliberalismo y ascenso de la nueva derecha. CLACSO, Ciudad Autónoma de Buenos Aires

Lustig, Nora. (2016). Privilegios que niegan derechos. Oxfam International.

Mark M, Henry G, Julnes G (2000) Evaluation: an integrated framework for understanding, guiding, and improving policies and programs, Jossey-Bass, San Francisco

McQueen DV, Wismar M, Lin V, Jones CM (2012) Introducción: Salud en Todas las Políticas, los determinantes sociales de la salud y la gobernanza. In: McQueen DV, Wismar M, Lin V, Jones CM, Davies M (eds) Gobernanza Intersectorial para la Salud en Todas las Políticas. World Health Organization, Geneva

Ministerio de Salud y Protección Social (2016) Resolución Número 003202-2016. Minsalud, Colombia

Muñoz M, Cabieses B (2008) Universidades y promoción de la salud: ¿cómo alcanzar el punto de encuentro? Salud Pública 24(2):139–146

PAHO (2016) Hoja de Ruta para el Plan de Acción sobre la Salud en Todas las Políticas. PAHO, Washington, DC

Quesada Monge AC, Picado Herrera LI (2014) Educación continua en promoción de la salud, desde una acción interinstitucional. Diálogos: Revista de Historia 15:125–143

Rasanathan K (2011) Cerrando la brecha: la política de acción sobre los determinantes sociales de la salud. Conferencia mundial sobre los Determinante Sociales de la Salud. OMS, Rio de Janeiro

Robledo-Martínez R, Agudelo-Calderón CA (2011) Aproximación a la construcción teórica de la promoción de la salud. Salud Pública, Univ Nacional de Colombia 13(6):1031–1050

Rojas Ochoa F (2003) El desarrollo de la economía global y su impacto sobre las políticas de salud. Salud Pública 29(3):253–259

Sapag JC, Kawachi I (2007) Capital social y promoción de la salud en América Latina. Revista Saúde Pública 41(1):139–149

Solimano G, Valdivia L (2014) Salud Global en las instituciones académicas latinoamericanas: hacia un desarrollo e identidad propia. Saúde Soc São Paulo 23(2):357–365

Tones K (2005) Health promotion in schools. The radical imperative. In: Clift S, Jensen BB (eds) The Health Promoting School: International Advances in Theory, Evaluation and Practice. Danish University of Education Press, Copenhagen

United Nations (2013) La alianza mundial para el desarrollo: el desafío pendiente. Informe de 2013 del Grupo de Tareas sobre el desfase en el logro de los Objetivos de Desarrollo del Milenio. Nueva York

Waitzkin H (2006) One and a half centuries of forgetting and rediscovering: Virchow's lasting contributions to social medicine. Soc Med 1(1):5–10

World Health Organization (1986) The Ottawa Charter for health promotion. 1(4):III–V

World Health Organization (1998) Promoción de la Salud Glosario. World Health Organization, Ginebra

World Health Organization (2003) Health Systems: principled integrated care. WHO, Geneva

World Health Organization (2005) Carta de Bangkok para la promoción de la salud. Tailandia

World Health Organization (2016) Intersectoral action for health—experiences from small countries in the WHO European Region. Copenhagen, Denmark

World Health Organization (2017) The 2017 Healthy Cities Pécs Declaration European Healthy Cities Network adopts the Pécs Declaration. WHO